Instructions to Health Plans

* [Plans should replace the word “Medicaid” with “Mass Health”.]
* [Plans should replace references to “Medicaid” with the term the plan uses”]
* [Plans should note that any reference to a “Member Handbook” is also a reference to the Evidence of Coverage document.]
* [Plans should add or delete the categories in the “Services you may need” column to match State-specific benefit requirements.]
* [For the “Limitations, exceptions, & benefit information” column, plans should provide specific information about need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, permissible OON services, and applicable cost sharing (if different than in-plan cost sharing).]
* [The multi-language insert is a document that contains language translated into multiple languages (Spanish, Chinese Mandarin, Chinese Cantonese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, Cambodian, Laotian, and Haitian Creole) regarding the availability of interpreter services. Regardless of the CMS or State translation requirements, all plans must include the CMS created multi-language insert as specified in the Medicare Marketing Guidelines.]
* [Plans may place a QR code on materials to provide an option for members to go online.]

This is a summary of health services covered by <plan name> for <date>. This is only a summary. Please read the Member Handbook for the full list of benefits.

* <Plan’s legal or marketing name> is a health plan that contracts with both Medicare and MassHealth to provide benefits of both programs to enrollees under the <Massachusetts Demo Name>. It is for people with both Medicare and MassHealth ages 21 through 64 at the time of enrollment.
* Under <plan name> you can get your Medicare and MassHealth services in one health plan called a <Massachusetts Demo Name> plan. A <plan name> care coordinator will help manage your health care needs. [Plans should change “care coordinator” to the term used by the state and/or plan.]
* This is not a complete list. The benefit is a brief summary, not a complete description of benefits. For more information you can call<plan name> Member Services or read the <plan name> Member Handbook.
* Limitations, [copays,], and restrictions may apply. For more information, call <plan name> Member Services or read the <plan name> Member Handbook.
* Benefits, List of Covered Drugs, pharmacy and provider networks [and/or copayments] may change on January 1 of each year.
* [For plans with Copays ] Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.]
* You can get this document in Spanish, or speak with someone about this information in other languages, for free. Call <toll-free number>. The call is free. [The preceding sentence must be in English and Spanish. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]

## The following chart lists frequently asked questions.

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| **Frequently Asked Questions (FAQ)** | **Answers** |
| **What is <Massachusetts Demo Name> plan?** | The <Massachusettes Demo Name> plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care coordinators to help you manage all your porviders and services and supports. They all work together to provide the care you need. <Plan Name> is a health plan that provides benefits of MassHealth and Medicare to enrollees the <Massachusetts Demo Name>. [Plans should change “care coordinator” to the term used by the state and/or plan] |
| **What is a <plan name for care coordinator>?** | A <plan name for care coordinator> is one main person for you to contact. This person helps to manage all your providers and services and make sure you get what you need. [Plans should change “care coordinator” to the term used by the State and/or plan.] |
| **What are long-term services and supports?** | Long-term services and supports are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. |
| **What is an Independent Living and Long-term Services and Support (IL-LTSS) Coordinator?** | A <plan name> IL-LTSS Coordinator is a person for you to contact and have on your care team who is an expert in long-term services and supports. This person helps you get services that help you live independently in your home. |
| **Will you get the same Medicare and MassHealth benefits in <plan nme> that you get now?** | You will get your covered Medicare and Medicaid benefits directly from <plan name>. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change. You may also get other benefits the same way you do now, directly from a state agency like the Department of Mental Health or the Department of Developmental Services. When you enroll in <Plan name>, you and your care team will work together to develop an Individualized Care Plan to address your health and support needs, reflecting your personal preferences and goals. During this time, you can continue to receive all the same Medicare and MassHealth benefits that you get now for 90 days or until your care plan is completed. |

| **Frequently Asked Questions (FAQ)** | **Answers** |
| --- | --- |
| **Can you go to the same doctors you see now?** | Often that is the case. If your providers (including doctors, therapist, pharmacies, and other health care providers) work with <plan name> and have a contract with us, you can keep going to them. Providers with an agreement with us are “in-network.” You must use the providers in <plan name>’s network. If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of <plan name>'s plan. [*Plans may insert additional exceptions as appropriate.*]  To find out if your doctors are in the plan’s network, call Member Services or read <plan name>’s Provider and Pharmacy Directory.  If <plan name> is new for you, we will work with you to develop an Individualized Care Plan to address your needs. You can continue seeing the doctors you go to now for 90 days or until the care plan is completed. |
| **What happens if you need a service but no one in <plan name>’s network can provide it?** | Most services will be provided by our network providers. If you need a service that cannot be provided within our network, <plan name> will pay for the cost of an out-of-network provider. |
| **Where is <plan name> available?** | The service area for this plan includes: [*Plans should enter* county ***or*** counties] Counties [*plans should enter \* to denote partial county*], <State>. You must live in [*plans should enter* this area ***or*** one of these areas] to join the plan. [*Plans enter if applicable:* \* denotes partial county] |
| **Do you pay a monthly amount (also called a premium) under <plan name>?** | You will not pay any monthly premiums to [*Plan name]* for your health coverage.  If you pay a premium to MassHealth for CommonHealth, you must continue to pay the premium to MassHealth to keep your coverage. |
| **What is prior authorization?** | Prior authorization means that you must get approval from <plan name> before the <Massachusetts Demo Name> plan will provide coverage for a specific service, item or drug or out-of-network provider. <Plan name> may not cover the service, item or drug if you don’t get prior approval. **If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. <Plan name> can provide you with a list of services or procedures that require you to obtain prior authorization from <plan name> before the service is provided.** |
| **What is a referral?** | A referral means that your <primary care provider or care team> must give you approval to see a specialist.  A specialist is a provider with extra training. If you don’t get a referral from your <primary care provider or care team>, <plan name> may not cover the services. **<Plan name> can provide you with a list of services that require you to obtain a referral from your <primary care provider or care team> before the service is provided.** |
| **What is Extra Help?** | [If a plan is electing to reduce Part D co-payments to $0, the plan may delete this language and the future reference to Extra Help.]  Extra Help is a Medicare program that helps reduce your prescription drug program costs  such as copays. Your prescription drug copays under <Plan name> already include the amount of Extra Help you qualify for. For more information about this extra help, contact your local Social Security Office, or call Social Security at 1-800-772-1213. TTY users may call 1-800-325-0778. <Plan may substitute TTY/TDD number with or add contact information for Video Relay or other accessible technology.> |
| **Who should you contact if you have questions or need help?** | If you have general questions or questions about our plan, services, billing, or member cards, please call <plan name> Member Services.   |  |  | | --- | --- | | **CALL** | <Phone number(s)>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies.*]  Member Services also has free language interpreter services available for people who do not speak English. |   <TTY/TDD/other phone number>  **TTY <may substitute with or add contact information for Video Relay or other accessible technology>**  [*Insert if the plan uses a direct TTY number:* This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.]  [*Insert if the plan uses a video relay or other accessible technology number:* This number is for people who have hearing or speaking problems. [*Insert if applicable:* You must have special telephone equipment to call it.]  Calls to this number are [*Insert if applicable:* not] free. <Days and hours of operation.>  If you have questions about your health, please call the Nurse Advice Call line   |  |  | | --- | --- | | **CALL** | <phone number>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies.*] | |
|  | |  |  |  |  | | --- | --- | --- | --- | | **TTY <may substitute with or add contact information for Video Relay or other accessible technology>** | Member Services also has free language interpreter services available for fonon-English speakers.  <TTY/TDD/other phone number>  Calls to this number are [Insert if applicable: not] free. <Days and hours of operation.> | | | |  | |  |   If you need immediate behavioral health, please call the Behavioral Health Crisis Line   |  |  | | --- | --- | | **CALL**  **TTY <may substitute with or add contact information for Video Relay or other accessible technology>** | <phone number>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies.*]  Member Services also has free language interpreter services available  for non-English speakers. | |  | <TTY/TDD/other phone number>  Calls to this number are [*Insert if applicable:* not] free. <Days and hours of operation.> | |

The following chart is a quick overview of what services you may need, your costs and rules about the benefits

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| **Health need or concern** | **Services you may need** [This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the State.] | **Your costs for in-network providers** | **Limitations, exceptions, & benefit information (rules about benefits)** [Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-network cost sharing).] |
| **You want to see a doctor** | * Visits to treat an injury or illness | $0 |  |
| * Wellness visits, such as a physical | $0 |  |
| * Transportation to a doctor’s office | $0 |  |
| * Specialist care |  |  |
| * Care to keep you from getting sick, such as flu shots | $0 |  |
| * “Welcome to Medicare” (preventative visit one time only) | $0 |  |
| **You need medical tests** | * Lab tests, such as blood work | $0 |  |
|  | * X-rays or other pictures, such as CAT scans | $0 |  |
|  | * Screening tests, such as tests to check for cancer | $0 |  |

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| **Health need or concern** | **Services you may need** [This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the state.] | **Your costs for in-network providers** | **Limitations, exceptions, & benefit information (rules about benefits)** [Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-plan cost sharing).] |
| **You need drugs to treat your illness or condition**  *There may be limitations on the types of drugs covered. Please see <plan name>’s List of Covered Drugs (Drug List) for more information.* | Generic drugs (no brand name) | [Plans should insert a single amount, multiple amounts, or a minimum/maximum range] for a [must be at least 30-day] supply.  [Plans may delete the following statements if they charge $0 for all generic drugs.] Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.  If you have been in a nursing facility for at least 90 days, you will not have any copays for prescription drugs. | [Plans must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations and make clear that the cost sharing amount for these extended-day supplies is the same as for a one-month supply.] |
|  | Brand name drugs | [*Plans should insert a single amount, multiple amounts, or a minimum/maximum range*] for a [*must be at least 30-*day] supply.  [*Plans may delete the following statements if they charge $0 for all brand name drugs.]* Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.  If you have been in a nursing facility for at least 90 days, you will not have any copays for prescription drugs. |  |
|  | Over-the-counter drugs  Medicare Part B prescription drugs covered by *<plan name>*  Part B drugs include drugs given by your doctor in his or her office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the Member Handbook for more information on these drugs*.* | [*Plans should insert a single amount, multiple amounts, or a minimum/maximum range.*]  $0 |  |

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| **Health need or concern** | **Services you may need** [This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the State.] | **Your costs for in-network providers** | **Limitations, exceptions, & benefit information (rules about benefits)** [Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-network cost sharing).] |
| **You need therapy after a stroke or accident** | Occupational, physical, or speech therapy | $0 |  |
| **You need emergency care** | Emergency room services | $0 | [Plans must state that emergency room services must be provided OON and without prior authorization requirements.] |
|  | Ambulance services | $0 | [Plans must state that emergency room services must be provided OON and without prior authorization requirements.] |
|  | Urgent care | $0 | [Plans must state that emergency room services must be provided OON and without prior authorization requirements.] |
| **You need hospital care** | Hospital stay | $0 |  |
|  | Doctor or surgeon care | $0 |  |

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| **Health need or concern** | | **Services you may need** [*This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the state.*] | | **Your costs for  in-network providers** | | **Limitations, exceptions, & benefit information (rules about benefits)** [*Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-plan cost sharing).*] | |
| **You need help getting better or have special health needs** | | Rehabilitation services | | $0 | |  | |
| Chiropractic Care | | $0 | |  | |
| Medical equipment for home care | | $0 | |  | |
| Skilled nursing care and home health services | | $0 | |  | |
| Family Planning | | $0 | |  | |
| Nurse Midwife Services | | $0 | |  | |
| Abortion services | | $0 | |  | |
| Dialysis services | | $0 | |  | |
| Podiatry | | $0 | |  | |
| Prosthetics | | $0 | |  | |
| Orthotic services | | $0 | |  | |
| **You need eye care** | | Eye exams | | $0 | |  | |
| Glasses or contact lenses | | $0 | |  | |
| Other vision care | | $0 | |  | |

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| **Health need or concern** | | **Services you may need** [*This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the state.*] | | **Your costs for  in-network providers** | | **Limitations, exceptions, & benefit information (rules about benefits)** [*Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-plan cost sharing).*] | |
| **You need help getting better or have special health needs** | | Rehabilitation services | | $0 | |  | |
| Chiropractic Care | | $0 | |  | |
| Medical equipment for home care | | $0 | |  | |
| Skilled nursing care and home health services | | $0 | |  | |
| Family Planning | | $0 | |  | |
| Nurse Midwife Services | | $0 | |  | |
| Abortion services | | $0 | |  | |
| Dialysis services | | $0 | |  | |
| Podiatry | | $0 | |  | |
| Prosthetics | | $0 | |  | |
| Orthotic services | | $0 | |  | |
| **You need eye care** | | Eye exams | | $0 | |  | |
| Glasses or contact lenses | | $0 | |  | |
| Other vision care | | $0 | |  | |

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| **Health need or concern** | | **Services you may need** [*This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the state.*] | | **Your costs for  in-network providers** | | **Limitations, exceptions, & benefit information (rules about benefits)** [*Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-plan cost sharing).*] | |
| **You need dental care** | | Dental check-ups and Preventative Care | | $0 | |  | |
| Restorative and Emergency Dental Care | | $0 | |  | |
| **You need hearing/auditory services** | | Hearing screenings | | $0 | |  | |
| Hearing aids | | $0 | |  | |
| **You have a chronic condition, such as diabetes or heart disease** | | Services to help manage your disease | | $0 | |  | |
| Diabetes supplies and services | | $0 | |  | |
| **You have a mental health condition** | | Mental or behavioral health services | | $0 | |  | |
| **You have a substance use disorder** | | Substance use services | | $0 | |  | |
| **You need long-term mental health services** | | Inpatient and outpatient care and community-based services for people who need mental health care | | $0 | |  | |

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| **Health need or concern** | **Services you may need** [*This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the state.*] | **Your costs for  in-network providers** | **Limitations, exceptions, & benefit information (rules about benefits)** [*Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-plan cost sharing).*] |
| **You need durable medical equipment (DME) or supplies, such as (Note: this is not a complete list of covered DME or supplies. For a complete list of all covered DME or supplies contact: Member Services or refer to the Member Handbook)** | Wheelchairs, Canes, Crutches, Walkers, etc. | $0 |  |
| Devices and equipment that help you better use household items or a computer | $0 |  |
| Oxygen and respiratory therapy services | $0 |  |

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| **You need help living at home** | Home services, such as cleaning or housekeeping | $0 |  |
| Changes to your home, such as ramps and wheelchair access | $0 |  |
| Day Habilitation services | $0 |  |
| Services to help you live on your own (Home health care services or personal care attendant services) | $0 |  |
| Adult Day Health or other support services | $0 |  |
| Adult Foster Care and Group Adult Foster Care | $0 |  |
| **You need a place to live with people available to help you** | Nursing home care | $0 |  |
| **Your caregiver needs some time off** | Respite care | $0 |  |
| **Transportation** | Emergency Transportation | $0 |  |
| Transportation to medical appointments | $0 |  |
| Transportation to other services | $0 |  |

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read the <plan name> Member Handbook. If you have questions, you can also call <plan name> Member Services.

**Other services <plan name> covers:**

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| **Other services <plan name> covers**  (This is not a complete list. Call Member Services or read the Member Handbook to find out about other covered services.) | |
| [*Insert special services offered by your program. This does not need to be a comprehensive list.*] | [*Plans should include co-pays for pharmacy products, if/as applicable.*] |
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**Services <plan name> does not cover**

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| **Services <plan name> does not cover**  (This is not a complete list. Call Member Services to find out about other excluded services.) | |
| [*Insert any excluded benefit categories. This does not need to be a comprehensive list.* |  |
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**Your rights and responsibilities as a member of the plan**

As a member of <plan name>, you have certain rights concerning your health care. You also have certain responsibilities to the health care providers who are taking care of you. Regardless of your health condition, you cannot be refused Medically Necessary treatment. You can exercise these rights without being punished or adversely affecting the way <plan name> and its providers treat you. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the Member Handbook.

**Your rights include, but are not limited to, the following**:

* **You have a right to respect, fairness and dignity.** This includes:
* The right to get covered services without concern about race, ethnicity, national origin, religion, gender, age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discriminations under any state or federal law or regulation
* The right to receive, at your, request information in other formats (e.g., audio CD-ROM, large print, cassette, Braille) free of charge
* The right to be free from any form of restraint or seclusion
* The right not to be billed by providers
* The right to have your questions and concerns answered completely and courteously.
  + The right to freely apply your rights without any negative affect on the way <plan name> or your provider treats you
* **You have the right to get information about your health care.** This includes information on treatment and your treatment options, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
  + <Plan name>
  + The services we cover
  + How to get services
  + How much services will cost you
  + Names of health care providers and care coordinators
  + Your rights and responsibilities
* **You have the right to make decisions about your care, including refusing treatment.** This includes the right:
  + To choose a primary care provider (PCP). You can change your PCP at any time. You can call <insert number> if you want to change your PCP.
  + To choose an Independent Living and Long-Term Services and Supports Coordinator (IL-LTSS Coordinator).
  + To see a women’s health care provider without a referral.
  + To get your covered services and drugs quickly.
  + To know and receive all benefits, services, rights and responsibilities you have under <plan name>, Medicare and MassHealth.
  + To know what the outcome of your treatment options may be.
  + To refuse treatment as far as the law allows, even if your doctor advises against it.
  + To stop taking medicine.
  + To ask for a second opinion about any health care that your PCP or your care team advises you to have. <Plan name> will pay for the cost of your second opinion visit.
  + To create and apply and advance directive, such as a will or health care proxy.
* **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
* Get medical care for covered services within the time frames described in [the Member Handbook], and to file an appeal if you do not receive your care within those timeframes.
* Get in and out of a health care provider’s office. This means barrier free access for people with disabilities, in accordance with the Americans with Disabilities Act.
* Have interpreters to help with communication with your doctors, other providers, and your health plan. Call the <insert number> if you need help with this service.
* Have your Member Handbook and any printed materials from <plan name> translated into your primary language, and/or to have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
* Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.
* **You have the right to seek emergency and urgent care when you need it**. This means:
* You have the right to get emergency services, 24 hours a day, seven days a week, without prior approval in an emergency.
* You have the right to see an out-of-network urgent or emergency care provider, when necessary.
* **You have a right to confidentiality and privacy.** This includes:
  + The right to ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected.
  + The right to have your personal health information kept private, as well as anything you discuss with them. No personal health information will be released to anyone without your consent, unless required by law.
  + The right to have privacy during treatment.
* **You have the right to make complaints about your covered services or care.** This includes the right to:
  + Access an easy process to voice your concerns, and to expect follow-up by <Plan name>.
  + File a complaint or grievance against us or our providers. You also have the right to appeal certain decisions made by us or our providers.
* Ask for a state fair hearing from the state of Massachusetts.
  + Get a detailed reason why services were denied.
  + Disenroll from <plan name> and change to another <Massachusetts Customer Service Center at 1-800-841-2900. TTY users may call 1-800-497-4648. <Plan may substitute TTY/TDD number with or add contact information for Video Relay or other accessible technology.>

**Your responsibilities include, but are not limited to, the following**:

* **You have a responsibility to treat others with respect, fairness and dignity.** You should:
  + Treat your health care providers with dignity and respect.
  + Keep appointments, be on time, and call in advance if you’re going to be late or have to cancel.
* **You have the responsibility to give information about you and your health.** You should:
  + Tell your health care provider your health complaints clearly and provide as much information as possible.
  + Tell your health care provider about yourself and your health history.
  + Tell your heath care provider that you are a <Plan name> member.
  + Talk to your <PCP>, care team, care coordinator, or other appropriate individual per the <Massachusetts Demo Name plan care model> about seeking the services of a specialist before you go to a hospital (except in cases of emergencies or when you refer yourself for certain covered services).
  + Tell your <PCP>, care team, care coordinator, or other appropriate individual per the <Massachusetts Demo Name plan care model>
  + Within 48 hours of any emergency or out-of-network treatment.
  + Notify <plan name>’s Member service department if there are any changes in your personal information, such as your address or phone number.
* **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
  + Learn about your health problems and any recommended treatment, and consider the treatment before it’s performed.
  + Partner with your care team and work out treatment plans and goals together.
  + Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health..
* **You have the responsibility to obtain your services from <plan name>.** You should:
  + Receive all your health care from <plan name>, except in cases of emergency, urgent care, out-of-area. dialysis services, or family planning services, unless <plan name> provides a prior authorization for out-of-network care.
  + Not allow anyone else to use your <plan name> ID card to obtain healthcare services.
  + Notify <plan name> when you believe that someone has purposely misused <plan name> benefits or services.

You may be responsible for payment of services not covered by <Plan name>. A full list of the covered services is available in the Member Handbook.

For more information about your rights, you can read the <plan name> Member Handbook. If you have questions, you can also call <plan name> Member Services.

**If you have a complaint or think we should cover something we denied**

If you have a complaint or think <plan name> should cover something we denied, call <plan name> at   
<toll-free number>.You may be able to appeal our decision.

For questions about your rights, you can read the <plan name> Member Handbook. You can also call <plan name>  
Member Services.

[*Plans should include contact information for complaints, grievances, and appeals.*]

**If you suspect fraud**

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

* Call us at<plan name> Member Services. Phone numbers are on the cover of this summary.
* Or, call the MassHealth Customer Service Center at 1-800-841-2900. TTY users may call 1-800-497-4648.
* Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048.   
  You can call these numbers for free, 24 hours a day, 7 days a week.
* **[***Plans may also insert additional State-based resources for reporting fraud.*]